Pharmacy

Prior Authorization Criteria for Inhaled Corticosteroids

Background

The inhaled corticosteroids drugs include budesonide (Pulmicort Flexhaler), fluticasone propionate (Flovent Diskus/HFA), beclomethasone (QVAR), mometasone furoate (Asmanex Twisthaler/HFA), ciclesonide (Alvesco), flunisolide (Aerospan), and fluticasone furoate (Arnuity Ellipta). These drugs are used in the maintenance treatment of asthma.

What is Step Therapy?

Step therapy involves prescribing a safe, cost effective medication as the first step in treating a medical condition. The preferred medication is often a generic mediation that offers the best overall value in terms of safety, effectiveness, and cost. Non-preferred drugs are only prescribed if the generic is ineffective or poorly tolerated. **QVAR, Pulmicort Flexhaler, Alvesco, Aerospan**, **Asmanex Twisthaler/HFA,** and **Arnuity Ellipta** will only be approved for current and new users who are older than 12 years of age after they have satisfied the requirements to try the preferred agents on the Department of Defense (DoD) Uniform Formulary AND the clinical requirements listed below.

Prior Authorization Criteria for Inhaled Corticosteroids

PA criteria apply to all new users of **QVAR, Pulmicort Flexhaler, Alvesco, Aerospan**, **Asmanex Twisthaler/HFA,** and **Arnuity Ellipta** who are older than 12 years of age.

Automated PA criteria: The patient has filled a prescription for **Flovent Diskus** or **Flovent HFA** at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days.

AND

Manual PA criteria: QVAR, Pulmicort Flexhaler, Alvesco, Aerospan, Asmanex Twisthaler/HFA, and Arnuity Ellipta is approved (e.g., trial of Flovent Diskus or Flovent HFA is NOT required) if:

- Patient has experienced any of the following issues with Flovent Diskus or Flovent HFA, which is not expected to occur with the non-preferred ICS:
  - inadequate response to the step preferred drugs
  - intolerable adverse effects (patient has a history of adrenal suppression and the request is for Alvesco)
  - contraindication
  - patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk
  - No formulary alternative for the following: Pulmicort Flexhaler: patient is pregnant

Criteria approved through the DOD P&T Committee process May 2014

www.tricare.mil is the official Web site of the
Defense Health Agency,
a component of the Military Health System
7700 Arlington Blvd,
Falls Church, VA 22042

TRICARE Prior Authorization Request Form for

Inhaled Corticosteroids

6058

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TPharmPA@express-scripts.com**

Note: Prior authorization criteria applies for patients who are older than 12 years.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

1. Which medication is requested?	☐ **Pulmicort Flexhaler** (budesonide) – **Proceed to question 2** ☐ **All others** – **Proceed to question 3**	
2. *(Pulmicort Flexhaler/ budesonide request)* **Is the patient a female who is pregnant?**	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Has the patient tried Flovent Diskus or Flovent HFA and experienced an inadequate response or an intolerable adverse effect?	☐ Yes Sign and date below	☐ No Proceed to question 4
4. Does the patient have a contraindication to Flovent Diskus or Flovent HFA?	☐ Yes Sign and date below	☐ No Proceed to question 5
5. Has the patient previously responded to the requested agent and changing to Flovent would incur an unacceptable risk?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[17 December 2014]